PROGRESS

VOLUME I, NUMBER 4 MARCH, 1960

IN THIS ISSUE

THE ALCOHOLISM FOUNDATION OF ALBERTA

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The Alcoholism Foundation of Alberta is a private Foundation incorporated in 1951 under the Societies Act, financed by provincial and municipal grants, corporate and private contributions. The Foundation's three point program of Education, Treatment, and Research, is directed at the eventual Prevention of Alcoholism in Alberta. Patient counselling, medical, educational, and research services are provided through the two centres in Edmonton and Calgary. The Foundation recognizes alcoholism as a treatable illness, a serious public health problem, and therefore a public responsibility.

TREATMENT

Treatment services are available to anyone desiring help with a drinking problem. The treatment program includes individual counselling, medical treatment, and group therapy. A service fee of $10.00 is charged to the patient when he applies for treatment. No patient is ever denied treatment due to inability to pay.

There are no consulting fees.

Edmonton and Calgary out-patient clinic hours — 9 a.m. to 5 p.m.
Monday through Friday.

The Alcoholism Foundation of Alberta

Executive Director - MR. J. GEORGE STRACHAN

PROGRESS

Volume I, Number 4, Edmonton, March, 1960

PROGRESS is published every two months as part of the Foundation's Educational program in order that a more comprehensive knowledge, greater understanding, and more objective viewpoint of the illness alcoholism be provided the people of this province. All material in PROGRESS is believed to have been obtained from reliable sources, but no representation is made as to the accuracy thereof. Opinions expressed in the articles themselves are not necessarily those of The Alcoholism Foundation of Alberta, but are those of the authors reported.

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Comment

With this issue of Progress we come to the end of another fiscal year. The past year has been a progressive one; it has seen an extension of many of our services in education, treatment, and research, and we can now look forward to the accomplishment of many of our long-planned projects. A full report of the year's activities will be found in our Sixth Annual Progress Report, which will be published in a few weeks.

The first few months of this year have seen the broadening of our interests in many ways. Of particular importance was the extension of services to more communities. Through the invaluable cooperation of local "community advisory committees", facilities offering educational and treatment services are being initiated in Medicine Hat and Lethbridge. Members of the Foundation's Calgary centre will visit both centres regularly to participate in these services. Plans are underway to establish similar activities next in the Grande Prairie and Peace River area.

Requests for the use of our educational services have been noticeably expanded this year. We are now providing orientation and training sessions for Edmonton City Police Constables, student nurses, industrial groups, service clubs, schools, community seminars, members of the clergy, church groups, and others. Most welcome has been the many young people's groups who have requested talks.

We are very pleased at the appointment of Dr. E. M. Jellinek as Honorary Clinical Professor in Psychiatry by the University of Alberta, where he is lecturing on alcoholism to fourth year medical students. Dr. Jellinek, who is now Chief Consultant and Director of Professional Training with the Foundation, is giving unstintingly of his time and unique knowledge in discussions and lectures. This has had a most stimulating influence on all of us.

In December and January a special drive was organized in Edmonton and Calgary for those organizational funds necessary for the development of a program of evaluation, study, and research. I am happy to report that, through the excellent cooperation of Messrs. G. L. Crawford and D. K. Yorath, who sponsored luncheons to "kick off" the drive, the funds are coming along well.

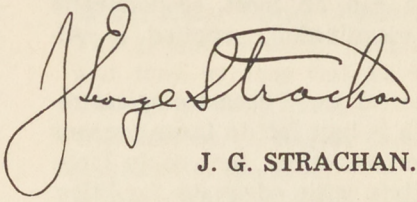
A year ago at the 1959 Legislative Session of the Provincial Government, recognition and unanimous approval of all parties was voiced regarding the need for further action on alcoholism, and the Foundation was noted as the representative body in the field of alcoholism for the Province. In this current Session of 1960, that measure of confidence is being fortified by a very heartening increase to our operating funds. This removes from us the instability of trying to plan operations from anticipated fund solicita-

tions, and so allows us to allocate all private contributions to the support and development of special services and research activities. This should further enhance our ability to seek sustaining membership donations for these objectives.

We can now foresee with real confidence the essential development of all Foundation activities. We have accomplished much; but this only helps us realize how much there is still to be done. We are always aware of the fact that, our total program being primarily remedial, the patient is ever our first and utmost concern. We would have achieved little success without the continued understanding and whole-hearted support, of not only those directly associated with the work of the Foundation, such as the Board and Executive, but also of our Provincial Government. Our recommendations have always been received by them with that warmth and understanding that makes possible an honest and well-designed review of immediate objectives and future hopes.

This year the Foundation will be host agency to the North American Association on Alcoholism Programs Eleventh Annual Meeting. This conference will be held at the Banff School of Fine Arts in September. As First Vice-President of this organization and Program Chairman this year, I feel that it is a great honor for Alberta to have been chosen as host agency.

This year 1960 will mark the Twenty-Fifth Anniversary of the fellowship of Alcoholics Anonymous. It will be celebrated by a conference of an anticipated ten to fifteen thousand members at Long Beach, California, in July. It is most fitting, therefore, that we again pay tribute to the tremendous contribution which the members and groups of Alcoholics Anonymous in Alberta continue to make to the recovery of those suffering from alcoholism. In Alberta A.A. will also be celebrating, I believe, its 15th Anniversary this year. Though the Foundation is in no way connected with Alcoholics Anonymous, nor is Alcoholics Anonymous in any way a part of Foundation activity, we do continue to receive a large number of our referrals from members and groups of Alcoholics Anonymous, and in turn, make every effort to have recovered patients in the Foundation transferred to an activity in A.A. Groups for a continuing program of recovery. In my opinion, no program can be completely successful without the cooperation and assistance of the membership of Alcoholics Anonymous. Fortunately, we do enjoy to a very great extent an excellent working rapport with this fellowship.

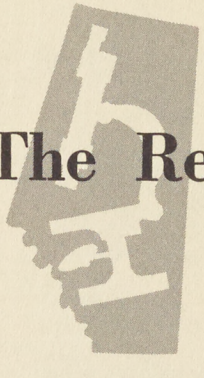


J. G. STRACHAN.

EDITOR'S NOTE

PROGRESS appears this month with a new format. Since the first issue nine months ago, the circulation of PROGRESS, now 5,500, had doubled. For this larger public of varied interests and occupations, we have redesigned PROGRESS, and by illustrating the articles, attempted to make the magazine as good-looking and readable as we can. PROGRESS will be published five times a year: in January, March, June, September, and November. Comments and requests for subscriptions are welcomed.

T. G. COFFEY.



The Research Program

By R. W. JONES

SINCE THE MAJOR FUNCTION of the Foundation's program is the prevention of alcoholism, our research work is primarily designed to develop basic information on which a broad-range educational and treatment program can be based.

There are three areas of research open to the Foundation:

1. Medical and Pharmacological Research;
2. Psychological and Psychiatric Research;
3. Sociological Research.

In considering these three areas of possible study, it is important that we try to select those projects which can be most economically and meaningfully applied in Alberta.

Medical and Pharmacological research is best left to those persons and organizations centred in large hospitals with adequate facilities. The Foundation would support worthy research programs in these areas if designed by persons with adequate research facilities in Alberta, but we would initiate few such studies ourselves.

Psychological and Psychiatric research are being carried out at quite an adequate level in many places. This does not rule out such research in Alberta, but does suggest that only projects of unusual local interest, with unusual facilities available, would warrant very elaborate or intensive studies. Man, in his individual processes, can be studied anywhere with results that are useful in most other places.

Sociological research, on the other hand, always is pertinent to a local scene. People in groups do not behave the same all over the world, as a result perhaps of the varied ethnic and social groups in which they live, kinds of work which they do, and economic and social activities in which they are engaged. This suggests then a very fertile field for investigation and research in Alberta.

Consequently, the Foundation is centering much of its research program on the development of information about the ways in which people drink. We are trying to learn what the social patterns involving drink are. We hope also to investigate the differences between various ethnic groups, social levels, and urban and rural dwellers in their attitudes toward beverage alcohol. These may seem to be unusual areas of research, but it has been shown in studies of small populations that each of these factors is related to the use and abuse of alcohol. Although the direct application of these investigations

might be limited to Alberta, such studies should prove beneficial to persons in other areas working with similar problems by offering new ways of perceiving and dealing with those problems.

While many activities of the research program will continue to be directed toward practical application in our educational and treatment programs, we do intend to introduce a few studies in theory, which will lead in a very direct way to practical results. It would be naïve, however, to assume that practical application can be derived from studies which lack sound basic design. Therefore, the Foundation must take an active interest in, and be a stimulant to, many kinds of theoretical research efforts in the field of alcohol studies.

SO MUCH for the general details of our research program. What are the specifics. Currently we are engaged in initial investigations on a broad range of problems, whose ultimate completion will depend upon factors of time, feasibility, and cost.

Geographical Distribution of Patients

In this study we are trying to find out which areas of the Province are adequately serviced, and which are poorly serviced. This will tell us where we should concentrate future education and treatment activity; what kinds of people have been attracted to our treatment program; and, by implication, what kinds of people have not. We should be able to discover some of our weaknesses and our strengths from this study.

Evaluation of Group Therapy

In this study we are investigating how people respond to our group therapy. In a preliminary approach to the problem we are examining the patients' attendance at group therapy sessions. It is tentatively planned to make a careful evaluation of a number of other group therapy activities.

Response to Advertising

Since much speculation has gone on throughout North America on how people become social drinkers —and this is undoubtedly related to how they become alcoholics—we are at present designing a study which will evaluate one aspect of this phenomenon: the effects of advertising in introducing people to social drinking. Since this is an extremely complex problem we decided to start with a study of the extent to which children respond to particular forms of advertising. This project is in the design stage and may or may not be carried through to completion.

Distribution of Deaths from Cirrhosis of the Liver

In this study we intend to examine the geographic distribution in Alberta of deaths from cirrhosis of the liver. Deaths from cirrhosis of the liver form the basic datum from which the estimates of alcoholism are made. We suspect that many areas in the province underreport cirrhosis deaths and that our estimates may be in error. This

study will, we believe, give us indications of where our information is weak.

"Who Knows What About the Foundation"

This study is an attempt to determine the extent to which people throughout the province have useful and useable information about the Foundation. The problem requires the use of very subtle and unusual techniques for obtaining the necessary information.

THIS BRINGS US to the two major studies contemplated at this time:

1. Drinking Patterns in Alberta;
2. Effects of Alcoholism Education and Treatment in Small Communities in Alberta.

Drinking Patterns in Alberta

In this study, we will describe the patterns of beverage alcohol use, of the extent of problem drinking, of the kinds of drinking (problem and otherwise), of the social controls and sanctions (both formal and informal) around drinking, and of the ethnic, religious, economic, ecological, and demographic factors related to the use of beverage alcohol. In short, we hope to obtain a clear understanding of the social function and role of beverage alcohol in the Province of Alberta. This cannot be accomplished overnight, nor can we hope to obtain all of this information in one study. Rather, we would do a series of studies spread over a number of years. Each of the studies would add to our knowledge about the use of beverage alcohol, so that eventually we would have a fairly clear picture of the pattern of use of beverage alcohol in Alberta. Such information will be invaluable for our educational and treatment programs.

Evaluation of Services to Small Communities

This is an experimental study designed to test the effects of our present treatment and education techniques when applied intensively in small communities in Alberta. If we find weaknesses in our methods, these will be varied so that we can develop suitable methods. We expect this to be a three year study which should produce important material, not only for Alberta, but also for the rest of Canada and the United States.

TAKEN AS A WHOLE, this appears to be an ambitious research program, but it is only enough to scratch the surface of what needs to be done. One of our major problems at all times is to assess what should, and what can be done. Setting priorities is not easy, but they are essential if we are to achieve a worthwhile research program around which treatment and educational activity may be directed toward the goal of prevention.

Mr. Robert W. Jones is the Associate Director, Research, of the Alcoholism Foundation of Alberta.

PREVENTION Through Education and Early Recognition

By C. ROBERT DICKEY, Information Officer

'PREVENTION is better than cure,' postulated the eminent Dutch Scholar, Desiderius Erasmus (1466-1536). In the eighteenth century the wisdom of that proposition was recognized by English proverb-writers, who, however, became more specific when they propounded that 'an ounce of prevention is worth a pound of cure.' This proverb has been quoted countless times since then, but it took mankind nearly four hundred years to catch up with Erasmus to the extent of establishing and labelling a distinct branch of medicine 'preventive medicine.'

During the past sixty or so years, tremendous strides have been taken in this field; we now feel reasonably safe from typhoid, smallpox, diphtheria, yellow fever, poliomyelitis, and some others. We can never entirely separate the curative from the preventive aspects of medicine, but now, prevention 'runs like a golden thread through the entire fabric of modern medicine'.

As an example of outstanding preventive work, consider the monumental accomplishments of the voluntary societies fighting tuberculosis. Their efforts, begun early in this century, have had the happy result of helping materially to reduce TB from the number one position among killers, down steadily and even spectacularly to a comparatively minor cause of death in 1959.

The past twenty to twenty-five years have seen increasing emphasis placed on prevention of TB, partly through the 'early diagnosis' campaign, partly through a skillful educational program directed toward all ages and segments of society, both public and professional. A fact which may be of significance to us is that from the beginning of that extremely successful campaign, TB workers avoided the former 'stigma' and 'hush-hush' aura that had surrounded the 'poor consumptive,' and approached the problem in a matter-of-fact, business-like manner that has paid off and will probably continue to do so.

We believe that the time has come for those concerned with alcoholism to recall the Napoleonic precept, 'attack is the best defense'; to do something about cutting down the need for more and more treatment and rehabilitation; to direct the emphasis toward reducing the incidence of serious alcoholism rather than providing more treatment facilities. We believe that an expanding program of education, intelligently planned, conducted with skill,

vigor, and tenacity, will help in earlier recognition and diagnosis. This may lead to earlier treatment and, we hope, earlier recovery.

But let us not be lulled by platitudes, trite sayings, and slogans into a false sense of security and complacency. It is so easy and comforting to say, "O.K., let's step up our educational program; let's harp on the slogan 'Early discovery means early recovery'; this will result in prevention of alcoholism, and prevention of much of its incalculable cost in money, human misery and human life." It is not as simple as all that.

THE SLOGAN 'Early discovery means 'early recovery' is true in the cases of a good many illnesses, and no doubt to some extent it is applicable to alcoholism. Unfortunately, however, alcoholism is so complex and still so incompletely understood, that there are still factors which militate against early recovery in many cases. Then again, there is that seemingly inexplicable inability or reluctance of the alcoholic to recognize his own ailment, in itself a symptom of the disease.

If the causes of the disease were largely or purely physiological, or psychological, or socio-cultural, or if we knew more about the combinations of elements that precede or lead into alcoholism, our problem would be simplified a good deal. Alcoholism is inextricably involved with many disciplines, branches of knowledge and arts and sciences. Biochemistry, biology, pathology, physiology, pharmacology, psychiatry, social science, public health, social and welfare work, law enforcement, religion, education — all these and more must be taken into consideration if we hope to come close to an understanding of the entire problem.

Our task is not lightened by the fact that alcoholism has a pernicious effect on many other public health problems, such as tuberculosis, epilepsy, heart ailments, diabetes, and others. Educational preventive work in these fields is also adversely affected. In fact, alcoholism might truly be said to bedevil all public health programs.

This emphasis on the difficulties facing us when we talk about education and prevention is not pessimism, but realism. We may now state our belief that in general, the 'early discovery' theory will have some application and will hold true for a large proportion of persons suffering from alcoholism. This will become more applicable as we recognize the difficulties and allow for them in our planning.

WE HAVE stated our objective in general terms; in a word, it is prevention. What, specifically, do we mean by prevention? What is it that we hope to prevent? Is it drinking, or drunkenness, or is it alcoholism?

Since ethyl, or beverage alcohol has been with us since prehistoric times, and since so many people use it, there is no valid reason to believe that it will not be with us for a long time to come, or that

people will suddenly, or ever, stop using it. Therefore, it seems to us only sensible and realistic to accept and deal with conditions that exist. Prior to Alcoholics Anonymous there had been attempts to treat and rehabilitate 'drunkards and inebriates' but they failed through lack of the practical and workable approach that has characterized AA and helped to make it so successful.

To carry our realism and acceptance of facts still further, the picture at this point is not too rosy, for experts have estimated that in Alberta alone, the alcoholic population increases by nearly 800 annually. We may reasonably assume that about 200 alcoholics die each year. Our records indicate that the Foundation returns about 200 alcoholics to the community in some stage of recovery yearly. Alcoholics Anonymous and other efforts account for perhaps a similar number. There is still an increase in the alcoholic population in Alberta, of about 200 per year.

Re-stated, the foregoing estimates suggest that all the services and programs combined can at best only 'decrease the increase' in the number of alcoholics, under present conditions and with our present facilities, staff, and financial resources. We do feel, when we compare the amount of money spent on treatment, education, and research in the field of alcoholism with money spent on many other diseases far less prevalent and devastating, that it is out of proportion, but there again we must do the best we can with what we have.

PREVENTION has been in the minds of alcoholism workers for a number of years, and many now believe that a sound preventive program can be divided into two categories, primary and secondary. Primary prevention may be achieved by working with young people who are approaching maturity in a society where drinking has wide acceptance; who have, in many cases, not yet begun to experiment with alcohol. Secondary prevention consists of early case-finding; of catching the potential or early alcoholic before compulsive drinking and loss of control take over.

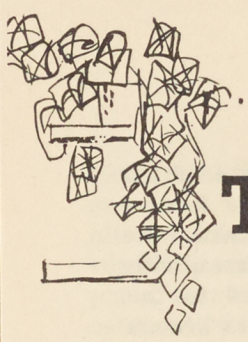
The Foundation's preventive program, both primary and secondary, has been in existence for several years. What we hope to do now is enlarge and extend our activities in the primary area, and plan further integration of all elements of the program to embrace increasingly effective work with departments of health and welfare, public and professional education, churches, business and industry, groups such as service clubs, home and school associations, libraries, radio, TV and press, motor associations, safety councils and departments, hospitals, other rehabilitation efforts, and so on and so on. All of this must be carried on simultaneously in separate projects, many of which are, however, closely interrelated and over-lapping.

(This is the first of four articles)

By E. M. CUTHBERTSON

SOME Canadian women will face a disturbing decision in 1960. These women will find themselves forced to recognize the fact that they are alcoholic. Alcoholism has found its victims among women just as long as women have been drinking, and with increasingly lenient social attitudes towards the use of alcohol by women we may expect a rise in the number of women alcoholics.

About 70% of the adult population of Canada have indicated that they drink in various amounts and with varying frequency. Based upon the numbers of deaths from cirrhosis of the liver occurring annually in Alberta, it is estimated



THE *Woman* ALCOHOLIC

that about 12,000 Albertans are recognizably alcoholic, of whom perhaps 2,000 are women. Another 18,000 persons are excessive drinkers, experiencing increasingly serious problems in one or more areas of their lives, domestic, vocational, or social, and many of these may be considered incipient or early stage alcoholics.

Here in The Alcoholism Foundation of Alberta we have seen 273 women patients during our six years of operation. The following figures, drawn from a sample of 79 women who had a significant period of treatment, indicate the average age, marital status, and occupation of these women alcoholics when they applied for treatment.

Average Age	38 years
Married	61%
Divorced, separated, or widowed	24%
Unmarried	15%
Housewives	53%
Employed	47%

No one occupation seems to have a monopoly of women drinkers. Our women patients have a wide range of occupations, including, for example: teachers, hairdressers, nurses, stenographers, domestics, business managers, housewives.

Perhaps the most painful and significant area of disruption that results from problem drinking in a woman is the effect upon her home. The majority of the persons coming to the Foundation were found to be experiencing difficulty in their family relationships.

When a woman begins to drink excessively, her ability to manage her household decreases. When one considers that the 79 women in our sample had 266 other family members, one can imagine something of the widespread and often devastating effects of alcoholism in women. It is certain that an alcoholic mother cannot provide a good emotional climate or consistent care for her children.

ONCE A pattern of excessive drinking is established in response to whatever cause, a woman finds herself the target of very direct criticism both at home and in the community. In our society drunkenness in women is held to be especially undesirable. This attitude of censure towards the heavy-drinking woman increases the tension she feels, and hence her need to drink to reduce the tension. This may become a dangerous circular process.

Within the shelter of her home it is often possible for a woman to drink to excess and yet escape detection until her disease is quite advanced. Alcoholism is still so shrouded by feelings of shame, that relatives hesitate altogether too long before treatment is instituted.

Although there are no legal restrictions which prohibit a woman from drinking by herself in public places, the majority in Alberta do not.

This illustrates very clearly that, insofar as drinking is concerned, a double standard exists for men and women. Women are aware of this double standard, and, therefore, when they become dependent upon drinking, they face a fearful conflict. Since we incline to integrate the values held in our society as our own, the alcoholic woman is keenly conscious that she is violating a commonly-held value if she gets intoxicated. This social stricture leads to much of the solitary, defensive pattern of drinking which we see in many women who retreat into their homes to drink by themselves. Of course it does not follow that if a woman were able to drink as she pleases, without any stigma attached to this behavior, she would never become alcoholic.

It has been observed that once a woman becomes alcoholic her progress into the later stages of the illness is more rapid than that of a man. Instead of ten years of excessive drinking to go from early to late stages of alcoholism, we may see a much shorter span in the female before serious consequences result.

One might consider that, when a woman has become alcoholic and faces the necessity of abstinence, it is easier for her to do so than for a man, because of the stronger

social pressures to drink exerted on a man. It is perhaps; but it is often harder for the woman to admit the need for help in the first place, because to do so marks her as an unworthy person in her own opinion. She therefore makes many unsuccessful attempts to cut down her drinking or to abstain completely on her own. When these efforts fail repeatedly, she is met by severe criticism from her family and friends, and feels, though mistakenly, that she is a moral failure.

When a man becomes dependent upon alcohol, he hears a good deal about applying will-power to control his drinking, but very little about the disease aspects of his condition. A woman is no less subject to this attitude from others, but, because of the double standard, she may feel even more obliged to conceal her illness which she believes to be evidence of moral or character weakness. A review of the women who have come to The Alcoholism Foundation for assistance with their drinking problems does not indicate that this group are in any way less responsible citizens or have lesser moral character than any other section of the general population.

DOES A WOMAN ever recover completely when she has developed alcoholism? Authorities agree that she will never be able to resume controlled drinking at any time in her life. She may be said to be recovering so long as she does not use alcohol at all.

Once she has stopped drinking a woman must face the hard task of adjusting to a life without alcohol. She may have to endure uncomfortable withdrawal symptoms and a further period of discomfort until the chemical and nutritional disorders accompanying alcoholism are cleared up. She may find it difficult to relate her physical condition to alcoholism, and there may be repeated relapses, until she finally accepts the necessity of complete sobriety for herself. Sobriety must become a most important and

vital consideration in her life if she is to be a functionally sound person.

Beyond the physical adjustments imposed by her illness, the woman alcoholic must also make a psychological adjustment in order to ensure the success of her sobriety. She must abandon the use of alcohol as a tension-reducing drug to satisfy her dependency and learn to meet this in ways which do not endanger her health or well-being. To do so, she will have to learn to accept life's realities as they occur, and in socially acceptable ways, so that she no longer needs the support of alcohol to avoid discomfort. Relearning when one is an adult is a difficult process, but it is essential if sobriety is to be maintained.

IN CONCLUSION, alcoholism among women is a real public health problem, and we must face the menacing proposition that changing feminine standards will very probably increase the potential victims of this illness.

When the illness occurs in women it seems to run a comparatively rapid course, and there is a possibility that recurrent or occasional stress, which may be precipitated by the reproductive cycle, difficult adaption to marital life and motherhood, or some other cause, may be a special factor in accelerating its course.

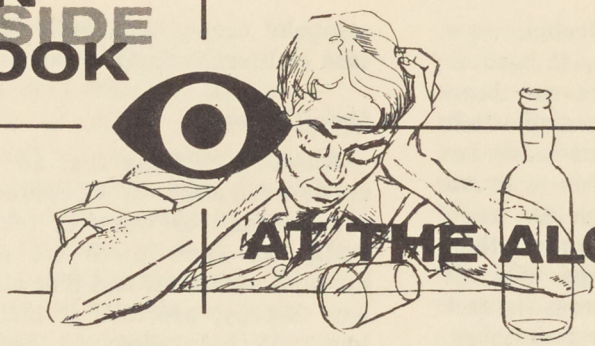
The traditional domestic role of a married woman may facilitate the development of problem drinking for some women, as may the protective or punitive attitude of those close to her.

Having once become an alcoholic, a woman is in the unfortunate position of having an illness which has such suspect symptoms that she feels she must conceal them from her family and friends, and she gets no sympathy or understanding when she displays symptoms inadvertently. In all probability she does not recognize that she has an illness; an illness so serious that, continued unchecked, it may be fatal for her.

For these reasons it is of the utmost importance that the symptoms of early developing alcoholism are recognized by the family, friends, relatives, physicians, and employers of the woman alcoholic, as well as the individual concerned. It is only when she has the approval and support of those around her that a woman is able to make a good recovery from alcoholism, and resume her useful role in her home and her community.

Miss E. M. Cuthbertson is a Counsellor and Supervisor of Treatment for the Edmonton Clinic of The Alcoholism Foundation of Alberta.

AN INSIDE LOOK AT THE ALCOHOLIC



By DENIS C. McGENTY

YOU CAN'T UNDERSTAND alcoholics by studying them from the outside in. If you take this approach you see only an irrational kind of behavior. What they do just doesn't make sense to you. To understand alcoholics, you must try to get inside their set of values, learn what motivates them to behave as they do, find out what makes them tick. You must study them from the inside out. Their behavior may still be irrational according to your set of values, but at least from theirs, you will see that their actions make sense.

I CALL alcoholics "outs." This name seems to be singularly suited, almost poetically appropriate, for these unfortunates. On their way down in the course of their progressive disease, they are increasingly passed out, conked out, out on their feet, out like a light, or just plain knocked out cold—literally out of this world! Their drinking habits and patterns are "outside" the accepted social norms. They are out of a job. Parents tell them to get out and stay out. Spouses order them out of the house. Bartenders throw them out. And at least until recently, judges were disposed to give them forty-eight hours to get out of town. They end up, down and out. The "outs" indeed.

How Do They Get That Way?

Certainly being an alcoholic is not a desirable condition to be in—viewed from the outside. Why, then are there alcoholics? Are they born with a tendency to drink? Are there certain types more prone to liquor? How do they get that way? Do other members of the family, perhaps unknowingly, actually help them on the treadmill? These are questions on which a considerable amount of light has been shed since experts have taken to viewing alcoholics from the inside out. We know that alcoholism

is a disease and the alcoholic is a seriously sick person. It also is known that people are not born alcoholics, or with a predisposition toward alcoholism. Extensive research has not been able to prove that persons of one type are more likely to become alcoholics, than persons of another type. Not all alcoholics are on skid row—in fact less than 15% are. And of these, only 25% are alcoholics—the rest are social misfits, professional beggars, psychopaths, and the like. So actually 88% to 92% of actual alcoholics are not flop-house characters. They live next door to you, work at the next desk, or factory bench, or possibly they are even closer to home than that. They may be a member of your family.

Four out of five alcoholics are employed or employable. At least one out of five is a woman. They are in all walks of life, all economic, educational, and social strata, regardless of race, creed, or color. Their illness ranks third as a national health problem, following only heart disease and cancer. But the outlook for an alcoholic can be far more hopeful than for the person having cancer. The alcoholic can be helped. His illness can be arrested. He can be restored to a happy and constructive role in family and community. For an understanding of what an alcoholic is, it is necessary to distinguish between him and simply a heavy drinker. A heavy drinker is one who can stop or cut down when he has a convincing reason. The alcoholic cannot stop even in the face of literally fatal reasons.

Many Types

We used to think that all alcoholics were alike—weak characters who couldn't or wouldn't take it. Today we know there are many kinds of alcoholics and that almost any therapy, provided it includes love, will help some of them. It always was thought that the alcoholic deliberately, with unfettered free will, chose to be what he is. But recently careful research has revealed two important points:

1. That early in life, especially during pre-adolescence, oftentimes parent-child relationships created the seed-bed for alcoholism;

2. That recurrent family relationships tend to trigger and retrigger the need to drink compulsively, and you will find four characteristics common to alcoholics:

(a) Egocentricity (a person extremely self-centered),

(b) Inability to face external pressures (in sociology, called 'low tolerance for tension'),

(c) Over-dependence, and

(d) Paradoxically, a sense of omnipotence.

It is my opinion that to the alcoholic (as he views it from the inside), all four of these traits are compensation mechanisms for a deep, underlying sense of inadequacy.

LET US TRACE what happens in an alcoholic and view life as he does from the inside.

First of all, in most cases, he has had some abnormal parent-child relationship. This marks him with a deep, persistent sense of being rejected, so that ever after he is painfully insecure. This insecurity affects his behavior. He becomes egocentric, with everything revolving about himself. To protect his frail ego against what he considers outside threats, he develops a belligerent exterior as a defense mechanism. To illustrate this attitude in another situation, suppose a person with a sore toe is in a crowd. His whole attention is focused on protecting the sore toe from being stepped on. To do this he may elbow and push others rudely, things he probably would not do if it were not for the sore toe. The insecurity developed early in life makes him dependent on others repeatedly as he confronts the realities of life. This increases his initial sense of worthlessness. He feels rejected. He feels he should be rejected. A "selective" sensitivity seeks out rejection where it occurs, anticipates and interprets rejection where none is offered. It makes him distrust, even blinds him to, evidence of acceptance.

Like an infant, he tries desperately time and again to walk alone and erect. But his lack of self-confidence, his low level of self-regard, and his painful sense of inadequacy trip him up repeatedly into the dependence he has loudly renounced. His one hope of escape is a never-never land of omnipotence, where insecurity will be no more and where no one will reject. There will be, at long last, acceptance. There will be love. The alcoholic does not know this is happening to him. He knows only the pain—constant psychic pain—and desperate loneliness. One day, by chance, he discovers alcohol, which in our modern culture and society is generally accepted. It is a magic elixir, not of intoxication, but to him one of elation. Instantly tension is relaxed. Gone suddenly is nagging insecurity. Elation brings an immediate sense of grandiosity, of omnipotence. No more dependence. The mouse becomes a giant, a demi-god striding the universe. It is my firm conviction that, to the alcoholic, alcoholism is the solution to his problem before it is the cause. From the inside out, his drinking makes sense. It is a defense mechanism.

A Rejecting God

Where he knows God at all, the alcoholic selects only certain attributes of God on which he dwells to the exclusion of their opposites. Based on his parent-conditioned insecurity, low self-regard and intense guilt feelings, he sees God as all-powerful, all-knowing, all-just. Since His justice is supreme, therefore He will punish evil, reject the unworthy, and therefore reject him. This unconscious, neurotic selectivity completely ex-

cludes an awareness of the opposite attributes of God, as all-loving, all-merciful, all-forgiving, imminently helpful. It is because a balanced understanding of God is restored through its program of personal conversion or "spiritual awakening" that Alcoholics Anonymous is so effective in the recovery of alcoholics! One authority, Dr. H. M. Tiebout, believes the force of religion in an atmosphere of hope and encouragement in the AA program produces a profound change in the typically egocentric, alcoholic personality, dominated by defiant individuality and drives for omnipotence. The negative characteristics of aggression, hostility, and isolation are replaced by peace and calm, and a lessening of inner tension.

THE TYPES of women who marry actual or potential alcoholics to answer a need of their own can be identified by their names. (1) Controlling Catherine, (2) Suffering Susan, (3) Punitive Polly, and (4) Wavering Winifred. Husbands of alcoholics also fall into four classifications. (1) Coddling Charlie, the long suffering martyr who mothers and spoils his child-wife; (2) Bewildered Bennie, who leaves furiously but comes running back; (3) Unforgiving Freddie, unrelenting and self-righteous; and (4) Sadistic Sam, the punishing, sadistic variety. All of these may control, suffer, punish, waver, and coddle loudly while the neighbors sympathize. But they want things as they are to satisfy an unconscious need of their own. In fact, when the alcoholic husband becomes abstinent, his wife, no longer able to satisfy her need and unable to adjust, reacts with severe depression, at times requiring that she be institutionalized. So while the wife may not be responsible for her husband's illness, she may be one of the reasons for this continued drinking.

The attitude of the family is extremely important in the rehabilitation of the alcoholic. The family should provide a therapeutic setting for recovery. I find that when we request the family member to come to our Alcoholism Information Center for a visit, usually the prompt and indignant response is, "What do you want to see me for? There's nothing wrong with me, He's the one!" But so often it isn't only "him." If I were asked to name the single family attitude most obstructive to recovery, I would say it is the tendency to verbalize an acceptance and understanding of alcoholism as a disease while emotionally rejecting the alcoholic as "weak-willed" and deliberate in his drinking. When family members do come in, they recite a long-accumulated litany of grievances. Then they listen patiently as the counsellor explains the nature of the disease, its compulsive character, the list of symptoms, the need in the family for courage, patience, sympathy, understanding, but above all, love.

"Yes, of course, I know it's a disease," they reply. "I know he's

sick. But don't you think, if he really loved me, he'd quit?"

This proves the person doesn't really understand. He wouldn't say to a cardiac, "Yes, John, I know you have heart trouble. I know you must have bedrest for six weeks. But, we can't afford for you to have heart trouble. Why don't you just stop it? If you really loved me, you would!" To help an alcoholic, you must understand him. To understand him, you must know him from the inside out. Only with an inside view will you really get to understand the alcoholic's make-up and thus, with love and patience, be able to help him.

Until his death last year Denis McGenty was Director of Professional Education of the National Council on Alcoholism. This article first appeared in 'Inventory', a publication of the North Carolina Alcoholic Rehabilitation Program. His untimely death is a tragic loss to this field. His was the overall approach, both practical and theoretical; his interest in several disciplines, particularly psychology, sociology, and education, will be sorely missed. He was an old friend, and one whose vocational and avocational interests made him respected and loved by all who knew him.

J.G.S.

ALCOHOLICS ANONYMOUS
— *The Twelve Traditions*

THE mythical "man in the street" who knows how drunks behave, even in their sober moments, often has occasion to wonder how the society of Alcoholics Anonymous, with more than 250,000 assorted ex-problem drinkers, ever manages to hang together.

There is, however, no denying the fact that A.A. has flourished since its founding in 1935. Today there are approximately 8,000 local groups of men and women who "share their experience, strength, and hope with each other, that they may solve their common problem and help others to recover from alcoholism." These groups are in about 70 countries in nearly every section of the globe. Each year sees several hundred new groups come into being.

What keeps these once irresponsible, often "hopeless" people from being enmeshed in the kind of problems—social and organizational—that, from their very nature, other societies have to face?

The first most pertinent answer is that A.A. is not really an organization. There is no hierarchy, no government, even at the local level. There are no dues or fees, no rules or regulations. And no one, not even the oldest members (those with the longest period of sobriety), ever speak for the movement locally, nationally, or internationally.

A.A. as an international fellowship has never had a single rule, although occasionally a local group may experiment with "regulations." The only true rule-maker in A.A. might be called John Barleycorn, Mr. Alcohol himself. For the members of this unique fellowship have observed over the years that, if they happen to get too far out of line in their thinking and acting about the business of staying sober, someone is apt to get drunk. Since every member is in the Fellowship for the express purpose of *not* being drunk, it is generally agreed that it doesn't make much sense to defy the fund of common sense experience that has been accumulated over the years.

This experience, culled from observation of A.A. operations in thousands of groups, has been reduced to twelve simple statements. These statements are known in the society as The Twelve Traditions and are regarded as helpful guides to the continuing survival of the loosely-knit A.A. group structure.

The average A.A. member is likely to be a bit more interested in these Traditions than is usually the case in some organizations with rigid constitutions and by-laws. This heightened interest stems from the fact that the A.A. member, feeling that he owes his continuing sobriety to the existence of the movement, is determined that

it shall, in fact, survive. He knows that if A.A. does not survive, his own survival is threatened. The risk may seem remote to the outsider, but most A.A.'s prefer not to take it.

BRIEFLY stated, the Twelve Traditions read as follows:

1. Our common welfare should come first; personal recovery depends on A.A. unity.
2. For our group purpose, there is but one ultimate authority—a loving God *as He may express himself in our group conscience.* Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never to endorse, finance, or lend the A.A. name to any related facility or outside enterprise lest problems of money, property, and prestige divert us from our primary spiritual aim.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. A.A. as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles above personalities.

This is the third in a series of articles relative to the fellowship of Alcoholics Anonymous as prepared and released by General Service Headquarters of Alcoholics Anonymous. The first two articles in this series covered "The Twelve Steps" and "Alcoholics Anonymous; What Is It?" In future issues "How the A.A. Member Stays Sobre," "Medicine Looks at Alcoholics Anonymous," and other releases from the A.A. headquarters in New York, will appear.

The important Twelfth Step on Anonymity simply means that, in print or on the air, a member's relation to the society is kept anonymous. Occasional "breaks" of anonymity have occurred in the past but they have been the exception, not the rule.

There are good reasons for "voluntary insistence" on anonymity, most members agree. They point out that many problem drinkers who need and want help might be discouraged from turning to A.A. if they have reason to believe their problem may be exposed publicly. Old-timers in the Fellowship also point out, significantly, that past experience indicates the "A.A. publicity seeker" more often than not does himself no good. Lapsing from humility, he frequently lapses from sobriety.

WHILE the Traditions, as outlined above, first appeared in movement literature in 1946 and were accepted by the movement at its first International Convention in Cleveland in 1950, they have never been regarded as rigid disciplines or as dogma. They are subject to continuing scrutiny and interpretation, both locally and at the annual meetings of A.A.'s representative General Service Conference. The Conference provides an important forum for the exchange of A.A. experience worldwide. It also symbolizes the essential unity with which individual members seek to make available to others their personal experience in coping with the problem of alcoholism.

The mere existence of the Twelve Traditions of course provides no assurance that they are always followed to the letter in every A.A. group. The Tradition of "local autonomy" is in itself a pretty fair guarantee that individual groups will always have plenty of leeway for experimentation.

In practice, however, nearly all A.A. groups that face a ticklish dilemma or even a serious split in membership, usually wind up by referring back to the Traditions for guidance. If the dissident minority still does not agree with the Traditions, it is perfectly free to pack up and start its own new group. Old-timers in A.A. are inclined to regard such recurring phenomena with tolerance. The only thing that really counts, they point out, is the continued sobriety of the individual members, and the continuing availability of A.A. to help the alcoholic who may one day turn to it for help.

A TYPICAL A.A. group naturally requires a minimum amount of informal service organization. A small committee may be agreed upon, by election or otherwise, to arrange for a meeting place, provide the coffee and snacks that are the hallmarks of an A.A. meeting, line up speakers for the meeting, take up the collection and handle other minor chores. But this committee in no sense "runs" the group and the usual practice is to rotate these officers at frequent intervals, usually twice a year. The principle of rotation, while not pro-

vided for specifically in the Traditions, is a vital part of the A.A. way of doing things, from the local level on up to international service headquarters.

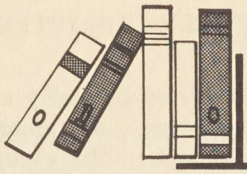
In a very meaningful way, The Twelve Traditions parallel the Twelve Suggested Steps of the program of personal recovery from alcoholism. Both the Traditions and the Steps are keyed exclusively to experience. Both allow ample room for individual interpretation. Both are intended basically as guides to the survival of alcoholics—personally and in the group structure of A.A.

Time, naturally, is the only true test of any tradition. The thousands of men and women who have found a new way of life in A.A. groups that adhere to The Twelve Traditions seem confident that time will only enhance the value of their voluntarily-adopted principles for group survival.

The question often arises, "Is there any connection between Alcoholics Anonymous and public level programs such as The Alcoholism Foundation of Alberta?" It should be clearly stated that there is NO connection between the Foundation and Alcoholics Anonymous, although every effort is made to achieve a close "working" relationship.

The position of Alcoholics Anonymous in this regard is better expressed by a quotation from the July 1959 A.A. Grapevine:

"A.A.'s Tradition of non-endorsement of outside enterprises was reaffirmed by delegates to the Ninth Annual General Service Conference in a resolution which also emphasized the right of A.A. members to work in and support such enterprises—serving strictly as individuals and not in any manner to be interpreted as "representatives" of Alcoholics Anonymous. The resolution also contains warm words of appreciation for the work of agencies in the field of alcoholism, promising full cooperation "short of affiliation." Finally, the resolution recommends that material such as "Co-operation, Yes—Affiliation, No" be supplied by GSO to areas where there is an apparent need for clarification of the relationship of A.A. with outside agencies."



Books

The Drinking Problem

By ANTHONY D'ALONZO, M.D.

Gulf Publishing Co., $2.95

Dr. D'Alonzo is Assistant Medical Director of E.I. du Pont de Nemours Co., and it would seem that this book was primarily inspired by the fact that the du Pont Company operate an educational and treatment program on alcoholism within the framework of their Medical and Industrial Relations Department.

The only unique feature found in this book was the author's decision to call a non-drinking alcoholic "a controlled alcoholic." From there on he proceeds to outline their approach to the problem, all strictly within the limits of the Yale School Plan for Industry.

Although most of the information given is factual and standard, one gets the feeling that the author obtained his material from publications on alcoholism rather than from any practical research or practice.

Dr. D'Alonzo starts with the usual 20 questions of the John Hopkins test for alcoholic tendency and then concludes that AA is still the only really effective therapy. This of course is quite understandable in that it is very well known that du Pont employ a full time counsellor on their staff who is himself a recovered alcoholic and member of AA.

He does outline Industry's role in the problem of alcoholism and gives six symptoms or signs which might indicate the employee has an alcoholic problem. He also acknowledges the role which the Doctor, Clergyman, Community, and immediate family may play in helping the patient's recovery.

Despite the widespread acclaim which has been justly accorded the du Pont Company Program, the author fails to develop any new element in working with the problem drinker. As a man who should know a great deal about alcoholism, he shows some rather glaring gaps in his knowledge and grasp of the subject. It appears to be just one more book that tends to over-simplify the situation, and again decides to dump it in AA's lap.

At best, it can be considered another voice added to the growing list stating that alcoholism is a problem and that some attempt is being made to cope with it in industry.

ROBERT T. DORRIS.

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- **PUBLICATIONS:**

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- **REFERENCE LIBRARY:**

  Books, pamphlets, and publications by authorities in the field of alcoholism.

- **SPEAKERS' BUREAU:**

  For professional, industrial, church, social, school, civic, and other groups requesting information.

The illustrations in Progress are by Harry Heine

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